Seizure and Epilepsy Clinic
W. David Strayhorn, MD, PhD - Epilepsy, Sleep Medicine
Shahid Rafiq, MD - Stroke, Sleep Medicine
Roderick Starkie, DO - General Neurology
Sean Burke, MD - Multiple Sclerosis, Neuromuscular

COMPREHENSIVE NEUROLOGY SERVICES
196 Thomas Johnson Dr. Ste 120
Frederick, MD 21702
Phone: 240-566-3130
Fax: 240-566-3131
www.thecns.com

NEW PATIENT QUESTIONNAIRE

Patient's Name: _____ Today's Date: _____

Please fill out as much of this questionnaire as you can before your appointment.

GENERAL QUESTIONS

☐ RH ☐ LH ☐ Ambidextrous

Who is with you today? _____

What is your primary goal for today's visit? _____

What other physician(s) have treated you for seizures in the past? _____
_____

Have you ever been diagnosed with epilepsy? _____
If so, have you been given a name for a specific type of epilepsy syndrome? (e.g., Juvenile Myoclonic Epilepsy, Temporal Lobe Epilepsy, Idiopathic Generalized Epilepsy, Partial or Focal Onset Epilepsy, Absence seizures, Lennox Gastaut Syndrome) _____
_____

When was your most recent seizure? _____

What are you currently taking for your seizures (if anything), and who is the prescribing doctor? _____
_____
_____
_____

Do you drive? ☐ Yes ☐ No

How did you find out about Dr. Strayhorn and the Seizure, and Epilepsy Clinic at Comprehensive Neurological Services? _____
_____

Patient initials: _____

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SEIZURE (or EVENT) DESCRIPTION

It is important to have as detailed a description of your seizures as possible, not only from your perspective, but also from the perspective of an observer. This can be accomplished by describing individual seizures (if you have had only one or a small number of seizures), by describing types of seizures (if you have had many seizures that are like one another), or by a mixture of both. Many people will have one type of seizure which varies in terms of severity; in this case, describe a "full-blown" seizure.

Be as detailed as possible in your descriptions. Include:

- warnings that you notice (if any) before a seizure starts
- warnings that others notice (if any) before a seizure starts
- what symptoms you experience before, during, and after a seizure
- whether your awareness or level of consciousness is altered
- how you act during a seizure from beginning to end
- whether there is shaking or trembling
- whether there is alteration of awareness or loss of consciousness
- how long a seizure typically lasts
- how you act after a seizure
- any other details you think are significant

Seizure or Seizure Type #1

If you have a name for this seizure type, what is it? Check on of the following, or write in your own name:
☐ grand mal ☐ petite mal ☐ convulsion ☐ blackout ☐ staring spell ☐ other: _____

Description from your perspective. (If you have no later memory other than what other people later tell you, simply state "no memory")

_____
_____
_____
_____

Description from an observer's perspective: _____
_____
_____
_____

Timing:
Date of this seizure (if you have had only one): _____
If you have had more than one, provide: _____
Date of the first seizure: _____ Date of most recent seizure: _____
State the frequency of this type of seizure; alternatively, state the total number of this type of seizure: _____
_____

Triggers:
Do you know of any ways to trigger your seizures? Check from the from following list, write any triggers not in the list, and elaborate in the space provided.
☐ stress ☐ sleep deprivation ☐ flashing lights ☐ alcohol consumption ☐ alcohol withdrawal ☐ menstrual period ☐ day time ☐ night time ☐ hyperventilation ☐ Other: _____
_____
_____
_____

Seizure or Seizure Type #2

If you have a name for this seizure type, what is it? Check on of the following, or write in your own name:
☐ grand mal ☐ petite mal ☐ convulsion ☐ blackout ☐ staring spell ☐ other: _____

Patient initials: _____

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Description from your perspective. (If you have no later memory other than what other people later tell you, simply state "no memory")

_____
_____
_____
_____

Description from an observer's perspective: _____
_____
_____
_____

Timing:
Date of this seizure (if you have had only one): _____
If you have had more than one, provide: _____
Date of the first seizure: _____ Date of most recent seizure: _____
State the frequency of this type of seizure; alternatively, state the total number of this type of seizure: _____
_____

Triggers:
Do you know of any ways to trigger your seizures? Check from the from following list, write any triggers not in the list, and elaborate in the space provided.
☐ stress ☐ sleep deprivation ☐ flashing lights ☐ alcohol consumption ☐ alcohol withdrawal ☐ menstrual period ☐ day time ☐ night time ☐ hyperventilation ☐ Other: _____
_____
_____
_____

Seizure or Seizure Type #3

If you have a name for this seizure type, what is it? Check on of the following, or write in your own name:
☐ grand mal ☐ petite mal ☐ convulsion ☐ blackout ☐ staring spell ☐ other: _____

Description from your perspective. (If you have no later memory other than what other people later tell you, simply state "no memory")

_____
_____
_____
_____

Description from an observer's perspective: _____
_____
_____
_____

Timing:
Date of this seizure (if you have had only one): _____
If you have had more than one, provide: _____
Date of the first seizure: _____ Date of most recent seizure: _____
State the frequency of this type of seizure; alternatively, state the total number of this type of seizure: _____
_____

Triggers:
Do you know of any ways to trigger your seizures? Check from the from following list, write any triggers not in the list, and elaborate in the space provided.
☐ stress ☐ sleep deprivation ☐ flashing lights ☐ alcohol consumption ☐ alcohol withdrawal ☐ menstrual period ☐ day time ☐ night time ☐ hyperventilation ☐ Other: _____
_____
_____
_____

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SEIZURE SYMPTOMS

Do you experience any of the following symptoms, either during a seizure or otherwise?

Y N

☐ ☐ **Staring Spells:** (Only consider spells that are out of the range of what you would consider to be commonplace or normal. For instance, everyone can daydream from time to time.) _____

☐ ☐ **Olfactory hallucinations**: (This refers to smells that you have good reason to suspect may not be "real" smells because other people cannot detect them anci you cannot identify a source of the smell.) If yes, are there any associated emotions or memories? _____

☐ ☐ **Déjà vu** or other abnormal memory symptoms: (A feeling that you have experienced something before when such is not actually the case.) _____

☐ ☐ **Autonomic symptoms:** (Examples include changes in heart rate, sweating, flushing, abnormal breathing) _____

☐ ☐ **Epigastric rising:** (Do you have a warm feeling in your stomach, feel nauseated, or get butterflies in your stomach?) _

☐ ☐ **Myoclonus:** (This refers to isolated twitches or jerking movements.) _____

☐ ☐ **Lost time:** (This refers to gaps in your memory that you cannot explain.) _____

☐ ☐ **Oral trauma:** (Do you bite your tongue or the inside of your cheek, either during a seizure or while you were sleeping?) _____

☐ ☐ **Incontinence:** (Do you lose control of your bladder or bowels either during a seizure or while you are asleep?) _____

☐ ☐ **Derealization**: (Do you have "out of body" sensations or feel like you are floating or observing yourself from a distance?) _____
_____

☐ ☐ **Chest pain:** _____
_____

☐ ☐ **Palpitations:** _____
_____

☐ ☐ **Orthostasis:** _____
_____

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SEIZURE RISK FACTORS

To the best of your knowledge, do you have a history of any of the following?

Comments

Y N

☐ ☐ **Family history of seizures or epilepsy** _____
_____
_____
_____

☐ ☐ **Febrile seizures (convulsions with a fever when you were a baby)** _____
_____
_____
_____

☐ ☐ **Head injury for which you received treatment (or think you should have received treatment if you didn't)** _____
_____
_____

☐ ☐ **Meningitis or encephalitis** _____
_____
_____

☐ ☐ **Stroke** _____
_____
_____

☐ ☐ **Brain tumor** _____
_____
_____

☐ ☐ **Aexual abuse** _____
_____
_____

☐ ☐ **Alcohol abuse** _____
_____
_____

☐ ☐ **Any other potential cause of seizures** _____
_____
_____
_____

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DIAGNOSTIC TESTING

Indicate whether you have or have not had any of the following tests and if so, indicate relevant information in the comments (when, who performed, result).

Comments

EEG: (electroencephalogram; recordings from 21 to 25 electrodes on your scalp which measure the brain's electrical activity)

Y N

☐ ☐ **Routine EEG (an EEG that typically takes no more than an hour or two to complete)** _____

☐ ☐ **Ambulatory EEG (an outpatient EEG that lasts overnight; may be with or without video)** _____

☐ ☐ **Epilepsy Monitoring Unit (a prolonged video EEG performed as an inpatient)** _____

IMAGING

☐ ☐ **Head CT (computed tomography; uses X-rays; typically takes just a few minutes to complete)** _____

☐ ☐ **Brain MRI (magnetic resonance imaging; usually performed in a small tube and triggers claustrophobia in some people: takes longer than a CT and is generally noisier)** _____

SPECIALIZED TESTING

☐ ☐ **SPECT (single-photon emission computed tomography)** _____

☐ ☐ **PET (positron emission tomography)** _____

☐ ☐ **WADA (intracarotid sodium amobarbital procedure)** _____

☐ ☐ **Neuropsychological evaluation** _____

☐ ☐ **Any other relevant testing** _____

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SEIZURE TREATMENT HISTORY

CURRENT SEIZURE TREATMENTS:

Indicate what medications you are currently taking for seizures. Include as much of the following as you are able: when you started the medication, the current dose, how well it is working, and side effects.

Drug Name	**Dose**	**Side Effects** (if any)	**Effectiveness**

Y N
☐ ☐ **Birth control** _____

☐ ☐ **Folate** _____

☐ ☐ **Vitamin D** _____

☐ ☐ **Calcium** _____

PRIOR TREATMENTS: Circle (or indicate using the checkboxes) which of the following medications you have been on in the past. Cross out the ones you have never taken. To the best of your ability, include the following pieces of information: date started, and date stopped, maximum dose, how well it worked, side effects, and any other pertinent information.

Y	N	Generic	Brand Name	Comments
		Lorazepam	Ativan	
		Acetazolamide	Diamox	
		Carbamazepine	Tegretol	
		Carbamazepine	Carbatrol	
		Clobazam	Onfi	
		Clonazepam	Klonopin	
		Clorazepate	Tranxene	
		Diazepam	Valium	
		Diazepam rect	Diastat	
		Divalproex sodium	Depakote	
		Ethosuximide	Zarontin	
		Felbamate	Felbatol	
		Gabapentin	Neurontin	
		Lacosamide	Vimpat	
		Lamotrigine	Lamictal	
		Levetiracetam	Keppra	
		Oxcarbazepine	Trileptal	
		Phenobarbital	Solfoton	
		Phenytoin	Dilantin	
		Pregabalin	Lyrica	
		Primidone	Mysoline	

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		Rufinamide	Banzel	
		Tiagabine	Gabitril	
		Topiramate	Topamax	
		Valproate sodium	Depacon	
		Valproic acid	Depakene	
		Vigabatrin	Sabril	
		Zonisamide	Zonegran	

Y N

☐ ☐ **Brain Surgery** _____
☐ ☐ **Vagal Nerve Stimulator** _____
☐ ☐ **Ketogenic Diet** _____
☐ ☐ **Acupuncture** _____
☐ ☐ **Meditation** _____
☐ ☐ **Hypnosis** _____
☐ ☐ **Other** _____

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GENERAL INFORMATION

MEDICATIONS (not seizure related, and not indicated elsewhere on this form):

Drug Name	**Dose**	**Side Effects** (if any)	**Purpose**

Are you allergic to any drugs? If so, please list them here:

Drug Name	Allergy

PAST MEDICAL HISTORY (not seizure related, and not indicated elsewhere on this form) Diagnoses, chronic illnesses, or other medical problems: _____

Surgeries:_____

Hospitalization:_____

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FAMILY MEDICAL HISTORY

Y	N		Relationship	Comments
		Parkinson's disease, or other movement disorder		
		Alzheimer's disease, or other dementia		
		Migraine		
		Cancer		
		Heart attack at an early age		
		Stroke at an early age		
		Obstructive sleep apnea		
		Other (list here)		

SOCIAL HISTORY:

What is your marital status? _____ Do you have children? _____

What is the highest level of education you have received? _____

What is your occupation? (Include whether you are a student, disabled, retired, etc.) _____

ALCOHOL USE

Have you had any drinks containing alcohol in the past year? ☐ Yes ☐ No

If yes, how often do you have a drink containing alcohol? (Check one)

☐ Never ☐ Monthly ☐ Two to four times a month
☐ Two to three times a week ☐ Four or more times a week

How many drinks with alcohol do you have on average? (Check one)

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

IF you answered more than 5 or 6 drinks, how often do you consume 5or 6 drinks with alcohol? (Check one)

☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily

TOBACCO USE

Are you a: ☐ current smoker? ☐ former smoker? ☐ never smoked?

If current smoker:

How often do you smoke Cigarettes?

☐ every day ☐ some days, but not every day

How many cigarettes a day do you smoke?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

How soon after you wake up do you smoke your first Cigarette?

☐ within 5 min ☐ 6-30 min ☐ 31-60 min ☐ after 60 min

Are you interested in quitting?

☐ ready to quit ☐ thinking about quitting ☐ not ready to quit

If former smoker: How long has it been since you last smoked?

☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 1-5 years
☐ 5-10 years ☐ more than 10 years